

Transcript Details

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ReachMD

www.reachmd.com
info@reachmd.com
(866) 423-7849

Detecting & Diagnosing Diabetes in Cardiology Patients

Dr. Sorrentino:

Since the introduction of statin medications in the late 1980s, prevention has become a major focus for cardiology to reduce the burden of cardiovascular disease. Major advancements in prevention have brought about significant changes in how cardiologists treat their patients.

You're listening to Heart Matters on ReachMD. I'm Dr. Matthew Sorrentino, and I'm speaking with Dr. Alan Brown about preventive cardiology.

There has been an explosion in new medications to treat diabetes that have shown a cardiovascular risk benefit, for example, the sodium-glucose cotransporter 2 inhibitors, SGLT2 inhibitors, such as empagliflozin and dapagliflozin reduce cardiovascular endpoints and reduce heart failure. Should cardiologists be prescribing these medications?

Dr. Brown:

I think so. If not prescribing them, indicating to the endocrinologist that the patient may be better served being on either an SGLT2 or if they don't have heart failure, a GLP-1 agonist. So, both of those have shown benefit in cardiovascular events and that was actually, sort of a shock to everyone. There was concern early on with the TZDs that they might actually increase cardiovascular morbidity and that lead to all drugs that are being approved to lower glucose having to be evaluated for whether or not they were causing negative cardiovascular outcomes, and much to the glee of everybody, these two classes of drugs actually showed benefit. I don't think that was expected. So there are cardiologists who are willing to use the drugs; some of them are worried about, for example, fungal infections in female patients with the SGLT2s, they may be inappropriately worried about hypoglycemia, which is highly unlikely and they're not comfortable managing diabetes. But every cardiologist should know that if they have a diabetic patient who has coronary artery disease and/or heart failure that the patient should be on one of these agents for their diabetes and talk to the primary care doctor or the endocrinologist if they're not on those drugs. And I think as they move into guideline-based care under cardiovascular guidelines we will see a shift in that direction. I personally think of diabetes as a cardiovascular disease and I'm somewhat disappointed that we haven't done a great job of teaching our colleagues a little more about diabetes and though I understand you can't know everything, about 10 years ago, I started an initiative at the ACC to teach all cardiologists about how to identify diabetes and make the diagnosis so they could at least tell a patient, "You have diabetes." I was somewhat surprised that many people did not know what fasting glucose would indicate diabetes or what A1C would indicate the diagnosis of diabetes. And they were interested. We had a huge number of cardiologists participate in that initiative. And then we talked about what could they do with oral agents to get the patient started on something while waiting to see an endocrinologist and even more importantly, which patients should emergently be sent to an endocrinologist, such as those with very high A1Cs or underlying liver or kidney disease. And the ball kind of got dropped on that; I think all of us got a lot of training on what types of drugs reduce cardiovascular risk in diabetics and much less so about the nuts and bolts of the diagnosis of diabetes, so that we have the courage to tell our patients, "You are a diabetic." And I'll just finish with why that's so important. A great endocrinologist, who's now retired, Steve Hafner, kind of coined the term "the ticking clock phenomenon" and what he talked about was that patients start to gain weight and get insulin-resistant, their HDL drops, their triglycerides go up and they have impaired fasting glucose, but not yet diabetes and during that period is when, with the hypertension, the dyslipidemia, impaired fasting glucose, pro-inflammatory state, the so-called "metabolic syndrome", they present with their heart attacks and we as cardiologists, often stent them and follow them regularly and then over the next few years, the ticking clock is that they develop type 2 diabetes. And oftentimes they're not told, "You have diabetes" when their blood-glucose is 130, you've got a borderline sugar, for example. So, people

need to be able to tell the patient, “You have diabetes. We need to initiate appropriate therapy. We need to make sure you’re on all the guideline-based preventative therapies and we need to start working on your A1Cs so that over the long-term, you have better outcomes.” And I think if we get there, and build a stronger tie with our endocrinology colleagues, we’ll do much better job of taking care of patients.

Dr. Sorrentino:

Well, you anticipated my next question, which was about that ACC program to teach cardiologists how to diagnose diabetes and begin simple treatments. I thought it was a great program at the time. Do you think we need another initiative like that? Should the ACC or one of the other groups help to better educate, not only cardiologists but internists because there’s not enough endocrinologists to go around to treat all our diabetic patients?

Dr. Brown:

Yeah, I absolutely agree, Matt. I think at the time, initially, some of the endocrinologists got irritated, and said, “Oh now you’re gonna tell me that cardiologists are gonna manage diabetes?”, and I said, “No, but there aren’t enough diabetologists and so we would like to help, at least, give the patient their diagnosis and begin appropriate therapy and we need you to teach us if you were gonna tell a bunch of novices what are the key things you need to think about in a patient that’s developing diabetes right in front of your eyes, what should we start with and then who should we send right away to an endocrinologist?” And once we got on that discussion, we joined forces with several leading endocrinologists and developed that program. And I do think that probably we should go beyond what happened then; we need cardio-diabetic clinics and as someone who is very interested in the future of healthcare, I don’t think we’re gonna be managing everybody in super-specialized clinics, but I do think the benefit of starting such a clinic where endocrinologists and cardiologists are working together to manage patients is that we learn the best practices, we learn how to make more simple algorithms and then we can be at the pulpit to teach our army of nurse practitioners and primary care doctors what the best practices are. Sergio Fazio has done something like this up at Oregon Health Sciences where he has a real preventative clinic that includes endocrine, internal medicine, and cardiology, and they manage all the risk factors in the patients who are at risk. And though I don’t think there’s enough specialists in the world to handle all of our future diabetics, I do think that those kind of centers really help develop protocols that could be sent out into the masses. And in fact, that’s our obligation. We become irrelevant when we tell everybody, “Only I know how to manage patients, you should send all your patients to me.” We really make a difference in the world when we say, “We’re going to take care of those really difficult, complex patients, but we’re gonna teach everybody else how to do a better job of taking care of the more common issues.” And that’s when we really make a dent in prevention.

Dr. Sorrentino:

Well, thanks, Alan for your insight into the state of prevention today. It was great to be able to discuss this with you, today, and see how the field is changing and continuing to grow. Thanks so much for joining us.

Dr. Brown:

Thank you very much, Matt.

Dr. Sorrentino:

I’m Dr. Matthew Sorrentino. To access this episode and others in this series, visit ReachMD.com/HeartMatters, where you can Be Part of the Knowledge. And thanks for listening.